DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Pharmacies
All Prescribers
Managed Care Plans

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

Memorandum No: 05-69 MAA
Issued: July 1, 2005

For More Information, call:
1-800-562-6188

Subject: Prescription Drug Program: Expedited Prior Authorization (EPA) Changes

Effective for the week of August 1, 2005, the Medical Assistance Administration (MAA) will implement the expedited prior authorization (EPA) changes to MAA's Prescription Drug Program that are outlined in this memorandum.

Expedited Prior Authorization (EPA) Additions

Off-label Use of Neurontin, Topamax, Keppra, and Gabitril

MAA, in conjunction with the Oregon Health Science University's Evidence-Based Practice Center, the Rand Corporation, and community stakeholder workgroups, has studied the evidence that supports the use of the second-line antiepileptic drugs listed in the table below for indications other than their FDA-approved indications. MAA is providing the EPA codes to allow immediate authorization of the drugs if client meets the corresponding criteria:

Effective the week of August 1, 2005, MAA will add the following EPA codes and criteria:

Drug	Code	Criteria
Gabitril® (tiagabine HCl)	036	Treatment of seizures
Keppra™ (levetiracetam)	036	Treatment of seizures
Neurontin® (gabapentin)	035 036	Post-herpetic neuralgia Treatment of seizures
Topamax®/Topamax® Sprinkle (topiramate)	036 045	Treatment of seizures Migraine prophylaxis

Note: Seizures have occurred in patients taking Gabitril for conditions other than epilepsy. In February 2005, a bolded "**Warning**" was added to the labeling for Gabitril® (tiagabine HCl) cautioning prescribers of the risk of seizures in patients without epilepsy**.**

PRIOR AUTHORIZATION IS NOT REQUIRED FOR ALL FIRST LINE ANTIEPILEPTIC AGENTS USED FOR SEIZURE DISORDERS.

Billing Instructions Replacement Pages

Attached are replacement pages H.9-H.12 and H.15-H.16 for MAA's current *Prescription Drug Program Billing Instructions.*

MAA's Provider Issuances

To view and download MAA's numbered memoranda and billing instructions electronically, visit MAA's website at http://maa.dshs.wa.gov (select the *Billing Instructions/Numbered Memoranda* link).

To request a free paper copy from the Department of Printing:

1. **Go to: http://www.prt.wa.gov/** (Orders filled daily).

   a) Click ***General Store***.

   b) If a **Security Alert** screen is displayed, click **OK.**

      i. Select either ***I'm New*** or ***Been Here***.
      ii. If new, fill out the registration and click ***Register***.
      iii. If returning, type your email and password and then click ***Login***.

   c) At the **Store Lobby** screen, click ***Shop by Agency***. Select ***Department of Social and Health Services*** and then select ***Medical Assistance*.**

   d) Select ***Billing Instructions, Forms, Healthy Options, Numbered Memo, Publications,*** or ***Issuance Correction***. You will then need to select a year and the select the item by number and title.

2. **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX (360) 586-6361/ telephone (360) 586-6360. (Orders may take up to 2 weeks to fill.)

Drug	Code	Criteria
Clozapine **Clozaril®**	018	All of the following must apply: a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is 17 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
Concerta® *(methylphenidate HCl)*	026	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
Copegus® *(ribavirin)*	010	Diagnosis of chronic hepatitis C virus infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).
Coreg® *(carvedilol)*	057	Diagnosis of congestive heart failure.
Dexedrine® *(D-amphetamine sulfate)*		See criteria for Adderall®.
Dextrostat® *(D-amphetamine sulfate)*		See criteria for Adderall®.
Duragesic® *(fentanyl)*	040	Diagnosis of cancer-related pain.

Drug	Code	Criteria
Enbrel® *(etanercept)*	017	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).
	024	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more DMARD.
	025	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.
Fazaclo® *(clozapine)*	012	All of the following must apply: a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is 18 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above; and d) Must have tried and failed generic clozapine.
Focalin® *(dexmethylphenidate HCl)*		See criteria for Concerta®.
Gabitril® *(tiagabine HCl)*	036	Treatment of seizures.

Drug	Code	Criteria
Geodon® *(ziprasidone HCl)*	046	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; and b) Patient is 6 years of age or older.
		Note: Because Geodon® prolongs the QT interval (< Seroquel® > Risperdal® > Zyprexa®), it is contraindicated in patients with a known history of QT prolongation (including a congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.
Geodon® IM Injection *(ziprasidone mesylate)*	058	All of the following must apply: a) Diagnosis of acute agitation associated with schizophrenia; b) Patient is 18 years of age or older; and c) Maximum dose of 40mg per day and no more than 3 consecutive days of treatment.
Glycolax Powder® *(polyethylene glycol)*	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.
Humira Injection® *(adalimumab)*	028	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients who have tried and failed one or more DMARD. Dose not to exceed 40mg subcutaneously every two weeks if patient is also receiving methotrexate, or up to 40mg subcutaneously every week if patient is not receiving methotrexate concomitantly.
Infergen® *(interferon alphcon-1)*	134	Treatment of chronic hepatitis C in patients 18 years of age and older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.

Drug	Code	Criteria
Intron A® *(interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.
	031	Diagnosis of recurring or refractory condyloma acuminate (external genital/perianal area) for intralesional treatment in patients 18 years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.
	033	Diagnosis of chronic hepatitis B in patients 1 year of age and older.
	107	Diagnosis of malignant melanoma in patients 18 years of age and older.
	109	Treatment of chronic hepatitis C in patients 18 years of age and older.
	135	Diagnosis of follicular non-Hodgkin's lymphoma in patients 18 years of age and older.
Kadian® *(morphine sulfate)*	040	Diagnosis of cancer-related pain.
Keppra™ *(levetiracetam)*		See criteria for Gabitril®.
Kineret Injection® *(anakinra)*	029	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients 18 years of age and older who have tried and failed one or more DMARD. Daily dose not to exceed 100mg subcutaneously.
Kytril® *(granisetron HCl)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.

Drug	Code	Criteria
Lamisil® *(terbinafine HCl)*		Treatment of onychomycosis for up to 12 months is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and requiring systemic antibiotic therapy;
	051	Peripheral vascular disease; **or**
	052	Patient is immunocompromised.
Levorphanol	040	Diagnosis of cancer-related pain.
Lotrel® *(amlodipine besylate/benazepril)*	038	Treatment of hypertension as a second line agent when blood pressure is not controlled by any: a) ACE inhibitor alone; or b) Calcium channel blocker alone; or c) ACE inhibitor and a calcium channel blocker as two separate concomitant prescriptions.
Lunesta™ *(eszopiclone)*	006	Short term treatment of insomnia. Drug therapy is limited to ten in 30 days, after which the patient must be re-evaluated by the prescriber before therapy can continue.
Metadate CD® *(methylphenidate HCl)*		See criteria for Concerta®.
Miralax® *(polyethylene glycol)*		See criteria for Glycolax Powder®
Naltrexone		See criteria for ReVia®.

Drug	Code	Criteria
Nephrocaps®	096	Treatment of patients with renal disease.
Nephro-FER® *(ferrous fumarate/ folic acid)* **Nephro-Vite**® *Vitamin B comp W-C)* **Nephro-Vite RX**® *(folic acid/vitamin B comp W-C)* **Nephro-Vite+FE**® *(fe fumarate/FA/ vitamin B comp W-C)* **Nephron FA**® *(fe fumarate/doss/ FA/B comp & C)*		
Neurontin® *(gabapentin)*	035	Post-herpetic neuralgia.
	036	Treatment of seizures.
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) Ansaid® *(flurbiprofen).* Arthrotec® *(diclofenac/misoprostol)* Bextra® *(valdecoxib)* Cataflam® *(diclofenac)* Celebrex® *(celecoxib)* Clinoril® *(sulindac)* Daypro® *(oxaprozin)* Feldene® *(piroxicam)* Ibuprofen Indomethacin Lodine®, Lodine XL® *(etodolac)* Meclofenamate Mobic® *(meloxicam)* Nalfon® *(fenoprofen)* Naprelan®, Naprosyn® *(naproxen)* Orudis®, Oruvail® (*ketoprofen*) Ponstel® *(mefenamic acid)* Relafen® *(nabumetone)* Tolectin® *(tolmetin)* Toradol® *(ketorolac)* Voltaren® *(diclofenac)*	141	An absence of a history of ulcer or gastrointestinal bleeding.

Drug	Code	Criteria
Oxandrin® *(oxandrolone)*		Before any code is allowed, there must be an absence of all of the following: a) Hypercalcemia; b) Nephrosis; c) Carcinoma of the breast; d) Carcinoma of the prostate; and e) Pregnancy.
	110	Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.
	111	To compensate for the protein catabolism due to long-term corticosteroid use.
	112	Treatment of bone pain due to osteoporosis.
OxyContin® *(oxycodone HCI)*	040	Diagnosis of cancer-related pain.
Parcopa® *(carbidopa/levodopa)*	049	Diagnosis of Parkinson's disease and one of the following: a) Must have tried and failed generic carbidopa/levodopa; or b) Be unable to swallow solid oral dosage forms.
PEG-Intron® *(peginterferon alpha 2b)*	109	Treatment of chronic hepatitis C in patients 18 years of age or older.
Pegasys® *(peginterferon alpha-2a)*	109	Treatment of chronic hepatitis C in patients 18 years of age or older.
Plavix® *(clopidogrel bisulfate)*	116	When used in conjunction with stent placement in coronary arteries. Supply limited to 9 months after stent placement.
	136	For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once-a-day aspirin therapy.
Pravachol® *(pravastatin sodium)*	039	Patient has a clinical drug-drug interaction with other statin-type cholesterol-lowering agents.
Prevacid® **Solutab** *(lansoprazole)*	050	Inability to swallow oral tablets or capsules.
Pulmozyme® *(dornase alpha)*	053	Diagnosis of cystic fibrosis and the patient is 5 years of age or older.
Rebetol® *(ribavirin)*		See criteria for Copegus®.
Rebetron® *(ribaviron/interferon alpha-2b, recombinant)*	008	Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.
	009	Treatment of chronic hepatitis C in patients with compensated liver disease.
Remicade Injection® *(infliximab)*	022	Treatment of rheumatoid arthritis in combination with methotrexate when prescribed by a rheumatologist in those patients who have had an inadequate response to methotrexate alone.

Drug	Code	Criteria
		• Liver function tests must be monitored periodically to guard against buprenorphine-induced hepatic abnormalities; and • Clients may receive up to 6 months of buprenorphine treatment for detoxification and stabilization.
		☞ **Note:** A Buprenorphine-Suboxone Authorization Form (DSHS 13-720) must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:** http://www1.dshs.wa.gov/msa/forms/eforms.html
Symbyax® *(olanzapine/ fluoxetine HCl)*	048	All of the following must apply: a) Diagnosis of depressive episodes associated with bipolar disorder; and b) Patient is **6** years of age or older.
Talacen® *(pentazocine HCl/ acetaminophen)* **Talwin NX®** *(pentazocine/naloxone)*	091	Patient must be **12** years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.
Topamax®/ Topamax® Sprinkle *(topiramate)*	036 045	Treatment of Seizures. Migraine prophylaxis.
Vancomycin oral	069	Diagnosis of clostridium difficile toxin and the patient has failed to respond after two days of metronidazole treatment or the patient is intolerant to metronidazole.
Vitamin ADC Drops	093	The child is breastfeeding and: a) The city water contains sufficient fluoride to contraindicate the use of Trivits w/Fl; and b) The child is taking medications which require supplemental Vitamin D, as determined medically necessary by the prescriber and cannot be obtained by any other source.
Vitamin E	105	Confirmed diagnosis of tardive dyskinesia or is clinically necessary for Parkinsonism and all of the following: a) Caution is addressed for concurrent anticoagulant treatment; and b) Dosage does not exceed 3,000 IU per day.
Wellbutrin SR and XL® *(bupropion HCl)*	014	Treatment of depression.
Xopenex® *(levalbuterol HCl)*	044	All of the following must apply: a) Patient is 6 years of age or older; and b) Diagnosis of asthma, reactive airway disease, or reversible airway obstructive disease; and c) Must have tried and failed racemic generic albuterol; and d) Patient is not intolerant to beta-adrenergic effects such as tremor, increased heart rate, nervousness, insomnia, etc.
Zelnorm® *(tegaserod hydrogen maleate)*	055	Treatment of constipation dominant Irritable Bowel Syndrome (IBS) in women when the patient has tried and failed at least two less costly alternatives.
	056	Chronic constipation when the patient has tried and failed at least two less costly alternatives.
Zofran® *(ondansetron HCl)*		See criteria for Kytril®.

Drug	Code	Criteria
Zometa® *(zoledronic acid)*	011	Diagnosis of hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors.
Zyprexa® Zyprexa Zydis® *(olanzapine)*		See criteria for Risperdal®.
Zyprexa® IM Injection *(olanzapine)*	060	All of the following must apply: a) Diagnosis of acute agitation associated with schizophrenia or bipolar I mania; b) Patient has been evaluated for postural hypotension and no postural hypotension is present before dose is given; c) Patient is 18 years of age or older; and d) Maximum dose of 30mg in a 24 hour period.
Zyvox Injectable® *(linezolid)*	013	Treatment of vancomycin resistant infection.
Zyvox Oral® *(linezolid)*	013	Treatment of vancomycin resistant infection.
	016	Outpatient treatment of methacillin resistant staph aureaus (MRSA) infections when IV vancomycin is contraindicated, such as: a) Allergy; or b) Inability to maintain IV access.